Gift to Agency Report — A Public Document

GIFT TO AGENCY REPORT

1. Agency Name

California Department of Health Care Services

Division, Department, or Region *(if applicable)*

Director's Office

Street Address

1501 Capitol Avenue

Area Code/Phone Number	**E-mail**
(916) 440-7418	brian.hansen@dhcs.ca.gov

Agency Contact *(name and title)*

Brian Hansen, Special Assistant to the Director

Date Stamp

California Form 801

For Official Use Only

☐ **Amendment** *(explain in comment section)*

Date of Original Filing: _____ *(month, day, year)*

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☒ Other Academy Health (Name)

1150 17th Street NW, Suite 600 (Address) | Washington (City) | DC (State) | 20036 (Zip Code)

Non-profit improving health and health care by advancing the fields of health services research and health policy.

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

If applicable, identify the name of each source and the amount(s) solicited or received by the donor for this gift:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

3. Payment Information

Date and Amount of Payment *(other than travel)* _____ *(month, day, year)* $_____ *(Round to whole dollars)*

Travel Payment Information *(Round to whole dollars)* **Location of Travel** Minneapolis, Minnesota, USA

Date(s) of Travel	Transportation Expenses	Lodging Expenses	Meal Expenses	Other Expenses	Total Expenses
August 3-6, 2010	$1364.00	$940.00	$N/A	$52.00	$2356.00

Provide a specific description of the nature and use of the payment for official agency business:

The payment was used to send DHCS staff to Academy Health's State Coverage Initiatives Annual Meeting. The Annual Meeting was designed to help states strategize and prioritize the implementation of the PPACA, including a state's governance and administrative decisions surrounding the operation of an Exchange.

Identify the officials for whom the payment was used:

Last Name	First Name	Title	Department/Division
Mollow	Rene	Division Chief	Medi-Cal Eligibility
Homman	Tanya	Division Chief	Medi-Cal Managed Care

4. Verification

I have determined that it is in the interests of the agency to accept this gift and use it for the official agency business described above.

Signature of Agency Head or Designee	Print Name	Title	*(month, day, year)*
Brian L. Hansen	Brian L. Hansen	Special Assistant to the Director	08/30/10

Comment: *(Use this space or an attachment for any additional information.)*